This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: 000-00-0000

ADJ12345
Case Number 1

☑ Specific Injury
☐ Cumulative Injury

02/02/2004
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

_____
Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LIENS AND BILLS

Document Title NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Document Date _____
MM/DD/YYYY

Date of document following Document Separator Sheet

Author UNIFORM ASSIGNED NAME

If no Uniform Assigned Name, "Author" is name of person/entity filing the lien. Example:
JOHN A SMITH
JOHN B SMITH MD
Use only capital letters and no special characters
e.g. / \ ' . " , : ; ( ) & !

Office Use Only

Received Date _____
MM/DD/YYYY

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien _____ (MM/DD/YYYY) ☐ Original Lien ☐ Amended Lien

CASE No. _____

(Choose only one)

☐ a Specific Injury on _____ (DATE OF INJURY: MM/DD/YYYY)

☐ a Cumulative Injury which began on _____ (START DATE: MM/DD/YYYY) and ended on _____ (END DATE: MM/DD/YYYY)

SSN Numbers Only) _____ (DATE OF BIRTH: MM/DD/YYYY) _____

Injured Worker

First name _____ MI _____

Last Name _____

Address/PO Box (Please leave blank spaces between numbers , names or words) _____

City _____ State _____ Zip Code _____

Attorney/Representative for Injured Worker

Name _____

Address/PO Box (Please leave blank spaces between numbers , names or words) _____

City _____ State _____ Zip Code _____

Lien Claimant (Completion of this section is required)

Organization _____

First Name _____

Last Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Phone _____

Lien Claimant Attorney/Representative

☐ Law Firm/Attorney ☐ Non Attorney Representative ☐ Lien Claimant not represented

Lien Claimant Law Firm/Representative

First Name

Last Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

Employer

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier or Claims Administrator Information

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $ _____ against any amount now due or which may hereafter become payable as
Total Lien Sum Amt
compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box) :

☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)

☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600.(Labor Code § 4903 (b).)

☐ Reasonable expense incurred by or on behalf of the injured medical-legal expenses (Labor Code § 4903 (b).)

☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury.(Labor Code § 4903 (c).)

☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)

☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)

☐ The reasonable fee for interpreter's services performed on _____ 20 ___ . (Labor Code § 4600 (f).)

☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)

☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)

☐ Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

☐ a copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

_____ (Signature of Attorney for Lien Claimant)

_____ (Signature of Lien Claimant)

_____ Date (MM/DD/YYYY)

Itemized Billing Statement

Itemized Billing Statement

Proof of Service